		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155790	B. WIN			07/03/2	012
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	KOVIDEK OK SUPPLIER			14751 (CAREY RD		
KINDREI	D TRANSITIONAL (CARE AND REHAB-BRIDGEWA	TER	CARME	EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	+	DATE
F0000							
	This is to confi	n In andication of	F00	00			
		r Investigation of	1.00	00			
	Complaints IN00109370 and						
	IN00109442.						
	Complaint IN00109370 - Substantiated. Federal/state deficiencies related to the						
	allegations are ci						
	anegations are en	nod ut 1 323.					
	Complaint IN00	109442 - Substantiated.					
	Federal/state deficiencies related to the allegations are cited at F202 and F203.						
		100d ut 1 202 und 1 203.					
	Survey dates: Jul	ly 2 and 3, 2012					
	Facility number:						
	Provider number						
	AIM number: 20	01023760					
	Survey team:						
	Chuck Stevenson	n RN					
	Melanie Strycke						
	Triolume Suryere	1 1111					
	Census bed type:	:					
	SNF: 53						
	SNF/NF: 33						
	Total: 86						
	10.001.00						
	Census payor typ	pe:					
	Medicare: 41						
	Medicaid: 15						
	Other: 30						
	Total: 86						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155790	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/03/2012
	ROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB-BRIDGEWATE	14751 (ADDRESS, CITY, STATE, ZIP CODE CAREY RD EL, IN 46033	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	Sample: 5			
	These deficiencies also reflect State findings in accordance with 410 IAC 16.2.			
	Quality review completed 7/7/12 by Jennie Bartelt, RN.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 2 of 29

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155790	B. WIN			07/03/	2012
NAME OF I	DROVADED OD GLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	L		14751 (CAREY RD		
		CARE AND REHAB-BRIDGEWAT	ER	CARME	EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0202 SS=D	When the facility resident under a specified in para this section, the must be docume must be made by when transfer or under paragraph (ii) of this section transfer or dischaparagraph (a)(2). Based on record facility failed to the clinical record assessments, care input to meet the refusing readmis following hospitabehaviors. This could be a section of 3 residents read discharge rig (Resident B). Findings include 1. The record of on 7/02/12 at 11: indicated diagnorate indicated diagnor	CHARGE OF RES transfers or discharges a ny of the circumstances graph (a)(2)(i) through (v) of resident's clinical record ented. The documentation by the resident's physician discharge is necessary a (a)(2)(i) or paragraph (a)(2) a; and a physician when arge is necessary under arge is necessary arge is ne	F02	02	This serves as the Allegation of Compliance for Kindred Transitional Care & Rehabilitation-Bridgewater for recent complaint survey dated 7/3/2012. Kindred-Bridgewater asserts that all corrections described on this Plan of Correction have been implemented. In regards to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of act The staff of Kindred-Bridgewater is committed to delivering high quality health care to its reside to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit Kindred-Bridgewater is in substantial compliance as set forth below, we are confident to it will be found in substantial compliance with regulations up re-survey. The statements man	the e ion. ter ents hat	07/20/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 3 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIG	00	COMPLETED	
		155790	A. BUII			07/03/2012	
			B. WIN				
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					CAREY RD		
KINDRE	O TRANSITIONAL (CARE AND REHAB-BRIDGEWATI	ΞR	CARME	EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
					on the plan of correction are n	ot	
	A hospital Admi	ssion History and			an admission to and do not		
	Physical prior to admission, dated				constitute an agreement with t		
					alleged deficiencies herein. F2		
	4/30/12, indicate	ed:			The facility ensures the reside	nt's	
					clinical record is documented		
	"Reason for hosp	oitalization:			correctly when transferring or		
	•				discharging.		
	1 Changa in ma	ntal status with acute			1.Resident B discharged to t		
		iliai status witti acute			hospital on 5/10/12 and did no	• • • • • • • • • • • • • • • • • • •	
	encephalopathy.				return to the facility, therefore,		
					further corrective action can be	5	
	2. Multiple other medical problems				taken for this resident.	- d	
	including diastol	•			2.A resident that is transferre		
	meraamg arastor	no noute fairate.			or discharged in a non-emerge nature will have proper	;iii	
			documentation that is appropriate			iate	
	_	22 narcosis (increased			and includes items identified in		
	blood level of ca	rbon dioxide)			the 2567: physician input,	'	
					assessments, care planning.	Δt	
	Past medical hist	tory.			this time there are no resident	• • • • • • • • • • • • • • • • • • •	
	1 dot incarcar mo				whose needs cannot be met		
					residing in the facility.		
	1. Chronic diasto	olic heart failure.			3.Licensed staff, the Social		
					Service supervisor and social		
	2. Chronic renal	failure, stage lll			service assistant will be		
		, 8			in-serviced on documentation	for	
	3. Obstructive sl				transfer/discharge of residents	,	
	3. Obstructive st	еер арпеа.			including but not limited to, the	;	
					proper method of discharge,		
	4. Previous histo	ry of DVT (deep vein			discharge planning, and		
	thrombosis; bloo	od clots)			documentation by the Staff		
	_	*			Development Coordinator or		
	5 Darinharata	renethy diagnosed in			Director of Nursing.		
	•	ropathy diagnosed in			4.The Medical Records		
	2009.				supervisor, or designee, will		
					review all transfer/discharges,		
	6. Status post mi	altiple orthopedic			ongoing to ensure proper		
	procedures inclu				documentation is in place. So	• • • • • • • • • • • • • • • • • • •	
	•	· ·			Service Director, or designee,		
	•	ateral shoulder surgery,			review findings and report to the	ie	
	right femur fract	ure.			Performance Improvement		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155790	B. WIN			07/03/2012	
			D. 172		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			CAREY RD		
KINDRE	D TRANSITIONAL (CARE AND REHAB-BRIDGEWA	TER		EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	7. Right oophore ovary)	ectomy (removal of			committee monthly for 3 month to determine need for continue monitoring thereafter. 5.Completion date: 7/20/12.		
	She has in the past been on Haldol for severe agitation						
	A hospital "Cons	sults" dictation, dated					
	5/03/12, indicate						
	,,,						
	"Reason for consultation: Altered mental status.						
	History of presen	nt illness:a history of					
	1	obstructive pulmonary					
	`	kidney disease,who					
	1	ered mental status.					
	presents with air	ered memai status.					
	Review of system	ms: Unable to complete					
	given the patient	•					
	Physical examin	ation:					
		difficult as the patient was					
	yelling loudly w	hile I was auscultating					
	(listening to hear	rt sounds)"					
	During an interv	iew with the Director of					
	Nursing (D.O.N.	.) on 7/02/12 at 11:30					
	a.m., she indicate	ed a Clinical Liaison					
	from the facility	had gone to the hospital					
	I -	person evaluation and					
	_	esident B prior to the					
		to accept her for					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet Page 5 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155790	B. WIN			07/03/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	R		14751 0	CAREY RD		
	O TRANSITIONAL (CARE AND REHAB-BRIDGEWA	ΓER	CARME	EL, IN 46033		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ĺ
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE	
	admission.						
	Nurse's progress	notes indicated:					
	5/09/12 2:55 a.m., "Resident is alert and oriented to self. Able to voice wants and						
		needs. Yelling loudly throughout shift;					
	1	rs and wanting someone					
	_	_					
	to stay in the room with her. Resident moved from original room with roommate to empty room due to yelling on earlier shift"						
	on carner sinit	•					
	5/09/12 9:51 p.n	n., "PT. (patient) is in					
	bed. She's still h						
		ontinue to monitor"					
	5/10/12 12:45 p.	m., "Exec Dir (Executive					
	Director), DON,	and (Social Services)					
	met with residen	nt's sister and resident's					
	daughter joined	via conference to discuss					
		ior and delirium and plans					
		esident's behavior.					
		nter has agreed to have					
		ck to hospital for thorough					
		(Interdisciplinary Team)					
		support as needed."					
		11					
	5/10/12 1:50 p.n	n., "Send to (acute care					
	hospital) to eval	(evaluate) and tx (treat)."					
	5/10/12 4:24 p.n	n "Pt has been					
		o (name of Acute Care					
		aluation and treatment"					
	1 1103p1tu1) 101 CV	aradion and treatment				1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 6 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	r í	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00		PLETED
		155790	B. WIN				3/2012
NAME OF F	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP COI	ЭE	
KINDDE	D TDANICITIONAL A	CARE AND DELIAR DRIDGEMA	TED		CAREY RD		
KINDREI	J TRANSITIONAL (CARE AND REHAB-BRIDGEWA	IER	CARIVIE	L, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	CTION	(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY		DATE
	D	to tall at the color					
	_	iew with the Executive					
	Director on 7/02/12 at 4:15 p.m., he						
		ring the above discussion					
		Resident B's family					
		e facility might not accept					
		to the facility after her					
		He also indicated that					
		members were advised					
	the facility woul	d not readmit Resident B					
	following her ho	spitalization both were					
	upset.						
	Resident B's Pro	gress Notes included no					
	documentation of	of any behaviors other					
	than the 2 noted	incidences of yelling on					
	5/9/12. The reco	rd included no					
	documentation of	of any concerns of a					
	decline, crisis, sa	afety concerns, or change					
	in her clinical co	ondition which would					
	require an imme	diate transfer.					
	•						
	An undated facil	lity document identified					
		s an assessment done at					
		Clinical Liaison for					
	1 2	her return to the hospital					
	on 5/10/12 indic	_					
	l and the second second						
	"Upon review of	f pt. notes, multiple					
	-	l pt. was agitated, yelling					
		communicate with. Pt.					
		arged) from BW (Kindred					
		e - Bridgewater) to					
		,					
	nospital due to s	evere agitation (symbol					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 7 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155790			LDING	ONSTRUCTION 00	(X3) DATE COMPL 07/03/	ETED		
	PROVIDER OR SUPPLIE	I RCARE AND REHAB-BRIDGEWAT	<u> </u>	14751 C	ADDRESS, CITY, STATE, ZIP CODE CAREY RD EL, IN 46033	1		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION	
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE	
TAG	for "and") (symbol status. Pt. has not bedside assessme cardiac, and wor place pt. at (name care facility)." A letter from Rephysician, dated the facility on the entirety: "(Resident B) we Bridgewater on the status of the st	cool for change) in mental of improved, per my ent. Due to behavior, and needs-would like to be of another long term sident B's facility treating 7/03/12, and delivered to at date, indicated in its as admitted to Kindred 5/8/2012 and was a accility less than 48 hours.		TAG	DEFICIENCY)		DATE	
	changes, increas and increased de made at that time							
	of a care plan wi interventions wo meet the residen contained no int on admission to behavioral conce	of an appropriate stermine if development						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet Page 8 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	COMPL	
THIND I LIMIT	or connection	155790		LDING		07/03/	
		100,00	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	01700	2012
NAME OF F	PROVIDER OR SUPPLIER	٤		1	CAREY RD		
KINDREI	TRANSITIONAL (CARE AND REHAB-BRIDGEWAT	ER	1	EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		f a physician's statement					
	_	needs the facility would					
		eet and why they would					
		eet them. The record					
		imentation the facility did					
	-	r intentions for Resident					
		the facility following					
	her hospital stay.						
	Resident B's fam	aily member #1 was					
		/05/12 at 9:50 a.m. She					
		ended a meeting on					
		cility concerning the					
		transfer Resident B back					
		he indicated the facility					
	-	d the reason for the					
		the resident's behavior of					
		the expectation the					
	-	ovide medication					
		ch would help with this					
	"	dicated she specifically					
		t B would be allowed to					
	return to the faci						
	hospitalization. S	•					
	_	for said, "Sure," the					
		ing said "Absolutely,"					
		ervices worker nodded					
		e indicated the facility did					
	not ask her to sig	•					
		she did not receive any					
		t the time of the meeting,					
	or since.	· · · · · · · · · · · · · · · · · · ·					
	Resident B's fam	nily member #2, who was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 9 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLE	ETED
		155790	A. BUI B. WIN			07/03/2	2012
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	R			CAREY RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-BRIDGEWA	ΓER		EL, IN 46033		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	responsible for r	naking health care					
	decisions for Re	sident B, was interviewed					
	on 7/05/12 at 10:00 a.m. She indicated						
	she participated	in the above meeting by					
		indicated the facility said					
	_	utely" when asked if the					
		eturn to the facility after					
		. She also indicated she					
		ed any discharge forms or					
	documentation.	ed any discharge forms of					
	documentation.						
	2. A facility policy dated 4/28/09 titled						
		sfer of the Resident"					
	indicated:						
	"Definitions:						
	Discharge: To le	eave the center without					
	_	n to return to the center					
	_	o home, a lower level of					
	l ' -	ong term care center,					
	death).	ong torm our contor,					
	deam).						
	Transfer: To loo	ve the center with plans					
		•					
		return (i.e., transfer to an					
	acute care center	r for appropriate care).					
	Procedure:						
	Discharge home	or another level of care:					
	1. Explain disch	arge procedure and					
	reason to resider	nt and give copy of					
		scharge Notice as					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet Page 10 of 29

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155790	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/03/2012
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB-BRIDGEWATE	14751 (DDRESS, CITY, STATE, ZIP CODE CAREY RD EL, IN 46033	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	required. Include family member/responsible party			
	2. Provide education to resident and/or family member/responsible partyItems/information that may be included in discharge planning may include, but is not limited to:			
	a. Where and from whom the resident will receive care			
	b. Resident's health condition			
	g. Summary of resident's current health status.			
	5. Complete a discharge summary and post discharge plan of care form			
	8. Have resident and /or family member/responsible party sign discharge summary and post discharge care form including release of medications.			
	9. Give copy of form to the resident and/or representative or person(s) responsible for care and place the signed original of the form in the resident's medical record"			
	This federal tag relates to Complaint IN00109442.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 11 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155790	(X2) MULTIPLE CO A. BUILDING B. WING	00	COME	E SURVEY PLETED 3/2012
KINDREI		CARE AND REHAB-BRIDGEWAT	14751 (ER CARME	ADDRESS, CITY, STATE, ZIP (CAREY RD EL, IN 46033	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	3.1-12(a)(5)(A) 3.1-12(a)(5)(B)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet Page 12 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155790	A. BUII			07/03/	/2012
		1667.66	B. WIN			01700	2012
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
					CAREY RD		
KINDRED	TRANSITIONAL (CARE AND REHAB-BRIDGEWATE	-R	CARME	EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0203	483.12(a)(4)-(6)						
SS=D		REMENTS BEFORE					
	TRANSFER/DIS	CHARGE					
	Before a facility t	ransfers or discharges a					
	resident, the faci	lity must notify the resident					
		family member or legal					
	•	f the resident of the transfer					
	•	I the reasons for the move in					
		anguage and manner they					
	•	ord the reasons in the					
		I record; and include in the					
		described in paragraph (a)(6)					
	of this section.						
	Eveent when one	ecified in paragraph (a)(5)(ii)					
		ne notice of transfer or					
		ed under paragraph (a)(4) of					
		t be made by the facility at					
		fore the resident is					
	transferred or dis						
	Notice may be m	nade as soon as practicable					
	before transfer o	r discharge when the health					
	of individuals in t	he facility would be					
	endangered und	er (a)(2)(iv) of this section;					
	the resident's he	alth improves sufficiently to					
		nediate transfer or					
	-	paragraph (a)(2)(i) of this					
		ediate transfer or discharge is					
	•	esident's urgent medical					
		ragraph (a)(2)(ii) of this					
	•	dent has not resided in the					
	facility for 30 day	/S.					
	The written notic	e specified in paragraph (a)					
		n must include the reason for					
		arge; the effective date of					
		arge; the location to which					
		ansferred or discharged; a					
		e resident has the right to					
appeal the action to the State; the name,							
		phone number of the State					
l		•					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet Page 13 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155790	B. WIN	G		07/03/	2012
NAME OF P	ROVIDER OR SUPPLIEF	· R			ADDRESS, CITY, STATE, ZIP CODE		
KINDRE	TRANSITIONAL (CARE AND REHAB-BRIDGEWATE	:R		CAREY RD EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	ICY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility residents disabilities, the relephone numb for the protection developmentally established under Developmental I Bill of Rights Act residents who an address and tele responsible for the of mentally ill income.	embudsman; for nursing with developmental mailing address and er of the agency responsible in and advocacy of disabled individuals er Part C of the Disabilities Assistance and it; and for nursing facility re mentally ill, the mailing ephone number of the agency he protection and advocacy dividuals established under and Advocacy for Mentally Ill					
	Based on record	review and interview, the	F0203		F203		07/20/2012
	facility failed to	ensure the resident was			The facility ensures a resident	ie	
	issued a Notice of	of Transfer or Discharge			issued a Notice of Transfer or	13	
	which included a	all the required			Discharge which includes all the	ne	
	information for 1	1 resident of 3 reviewed			required information is issued		
	for transfer and o	discharge rights and			when necessary.		
	notification in a	sample of 5. (Resident B)			1.Resident B discharged to the hospital on 5/10/12 and did no return to the facility due to the		
	Findings include):			facility, therefore, no further corrective action can be taken	for	
	on 7/02/12 at 11 indicated diagno not limited to, co hypertension, alt dementia, and che pulmonary disea admitted to the f	Resident B was reviewed :00 a.m. The record sees included, but were ongestive heart failure, tered mental status, senile aronic obstructive see. The resident was facility on 5/8/12.			this resident. 2.Residents that are to be transferred or discharged in a non-emergent nature are potentially at risk. Social Serv Director or designee will have proper documentation in place prior to event that is appropriat and includes items identified in the 2567: physician input, assessments, care planning at other necessary regulatory item 3.Licensed staff, the Social Service supervisor and social service assistant will be	te 1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 14 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO ILDING	onstruction 00	(X3) DATE COMPL		
		155790	A. BUI B. WIN			07/03/	2012
	F PROVIDER OR SUPPLIEF	I ≀ CARE AND REHAB-BRIDGEWA	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD TER CARMEL, IN 46033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	"Reason for hosp 1. Change in me encephalopathy. 2. Multiple other including diastol 3. Long-term Co blood level of ca Past medical his 1. Chronic diasto 2. Chronic renal 3. Obstructive sl 4. Previous histor thrombosis; blood 5. Peripheral neu 2009. 6. Status post me procedures inclure replacement, bilaright femur fract 7. Right oophore ovary)	pitalization: Intal status with acute In medical problems lic heart failure. D2 narcosis (increased urbon dioxide) Itory: Dlic heart failure. failure, stage Ill eep apnea. Dry of DVT (deep vein od clots) Irropathy diagnosed in Altiple orthopedic ding left knee ateral shoulder surgery,			in-serviced relative to notice requirements before transfer/discharge, including not limited to proper method discharge, discharge planning and documentation by the State Development Coordinator. 4. The Medical Records supervisor, or designee, will review all transfer/discharges ongoing, to ensure proper documentation is in place. Social Service Director, or designee, will review findings report to the Performance Improvement committee for 3 months to determine need for continued monitoring thereafter. 1. Completion date: 7/20/12	of J, aff , and	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 15 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155790	B. WIN			07/03/	2012
			F		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			CAREY RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-BRIDGEWA	ΓER		EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	severe agitation.						
	A hospital "Cons 5/03/12, indicate	sults" dictation, dated ed:					
	"Reason for constatus.	sultation: Altered mental					
	COPD (chronic disease), chronic	nt illness:a history of obstructive pulmonary c kidney disease,who ered mental status.					
	Review of system given the patient	ms: Unable to complete 's mental status.					
	Physical examin	ation:					
		lifficult as the patient was hile I was auscultating rt sounds)"					
	Nursing (D.O.N. a.m. she indicate the facility had g done an in-perso assessment of Ro	niew with the Director of a) on 7/02/12 at 11:30 and a Clinical Liaison from gone to the hospital and on evaluation and esident B prior to the to accept her for					
	Nurse's progress	notes indicated:					
	5/09/12 2:55 a.m	n. "Resident is alert and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet Page 16 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155790	B. WIN			07/03/2012
				STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIE	K		14751 C	CAREY RD	
		CARE AND REHAB-BRIDGEWA	TER	<u> </u>	L, IN 46033	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	+	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		Able to voice wants and				
		oudly throughout shift;				
	1	rs and wanting someone				
	-	om with her. Resident				
	moved from orig					
		pty room due to yelling				
	on earlier shift	."				
	5/09/12 9:51 p.n	n. "PT. (patient) is in bed.				
	•	g screaming episodes, will				
	continue to mon					
	5/10/12 12:45 p.	m. "Exec Dir (Executive				
	•	and (Social Services)				
	, · · · · · ·	at's (family member) and				
		y member) joined via				
	1 '	scuss resident's behavior				
		d plans to help resolve				
		ior. Resident's (family				
		reed to have resident sent				
	, ,	for thorough evaluation.				
	_	linary Team) will				
	continue to supp	• /				
	continue to supp	ort as needed.				
	5/10/12 1:50 p.n	n. "Send to (acute care				
	_	(evaluate) and tx (treat)."				
	5/10/12 4:24 p.n	n. "Pt. has been				
	transferred out to	o (name of Acute Care				
	Hospital) for eva	aluation and treatment"				
	During an interv	riew with the Executive				
	_	2/12 at 4:15 p.m. he				
		ring the above discussion				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet Page 17 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155790	B. WIN			07/03/2012
NAME OF B	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			14751 (CAREY RD	
	D TRANSITIONAL (CARE AND REHAB-BRIDGEWA	ΓER	CARME	EL, IN 46033	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	Dia relation,	DATE
		Resident B's family				
	members that the facility might not accept					
		Resident B back to the facility after her				
	_	He also indicated that				
		and daughter were advised				
	_	d not readmit Resident B				
	1	spitalization both were				
	upset.					
	Resident B's Pro	gress Notes contained no				
	documentation of	of any behaviors other				
		incidences of yelling on				
	5/9/12. The reco					
	documentation of	of any concerns of a				
		afety concerns, or change				
	•	ondition which would				
	require an imme					
	An undated facil	lity document identified				
	by the D.O.N. as	s an assessment done at				
	the hospital by a	Clinical Liaison for				
	Resident B after	her return to the hospital				
	on 5/10/12 indic	ated:				
	_	f pt. notes, multiple				
		l pt. was agitated, yelling				
		communicate with. Pt.				
	was d/cd (discha	arged) from BW (Kindred				
	Transitional Car	e - Bridgewater) to				
	hospital due to s	evere agitation (symbol				
	for "and") (symb	ool for change) in mental				
	status. Pt. has no	ot improved, per my				
	bedside assessm	ent. Due to behavior,				
	cardiac, and wou	and needs-would like to				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 18 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	а ріп	ILDING	00	COMPLE	TED
		155790	B. WIN			07/03/2	2012
			b. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			CAREY RD		
KINDREI	D TRANSITIONAL	CARE AND REHAB-BRIDGEWA	TER		EL, IN 46033		
					, 114 10000		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
		ne of another long term					
	care facility)."						
	A letter from Re	esident B's facility treating					
	physician dated	7/03/12 and delivered to					
		nat date indicated, in its					
	entirety:	,,					
	Chemoty.						
	"(Resident R) w	as admitted to (name of					
	` ′	· ·					
		2012 and was a resident in					
	1	than 48 hours. On					
		exhibited mental status					
		sed behavioral concerns,					
	and increased de	elirium. The decision was					
	made at that tim	e to transfer her to the					
	Emergency Dep	eartment at (name of acute					
		or evaluation and					
	• •	ich time she was					
	admitted."	Hen time she was					
	admitted.						
	Dagidant Dia maa	ord contained no					
		of any written notification					
		ne facility refused to					
		dent following her					
	hospital stay, no	notification of the right					
	to appeal the act	tion to the State, no					
	notification of c	ontact information for the					
	State long term	care ombudsman, or					
		ntation of the facility's					
		amily members of the					
		uning members of the					
	final discharge.						
	D 11 (D) 0	.1 1 //1					
		nily member #1 was					
	interviewed on '	7/05/12 at 9:50 a.m. She					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet Page 19 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	COMPL		
ANDILAN	or connection	155790		LDING		07/03/	
		100700	B. WIN		DDDDGG GYMY GM MD GYD GODD	017007	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE CAREY RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-BRIDGEWAT	ER		EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
	indicated she atte	ended a meeting on					
	5/10/12 at the fac	cility concerning the					
	facility's plan to	transfer Resident B back					
	to the hospital. S	he indicated the facility					
	specifically state	d the reason for the					
	transfer was for t	the resident's behavior of					
	yelling out, with	the expectation the					
	hospital could pr	ovide medication					
	adjustments which	ch would help with this					
	behavior. She inc	dicated she specifically					
	asked if Residen	t B would be allowed to					
	return to the faci	lity after her					
	hospitalization. S	She indicated the					
	Executive Direct	or said, "Sure," the					
	Director of Nurs	ing said, "Absolutely,"					
	and the Social Se	ervices worker nodded					
	her head yes. She	e indicated the facility did					
	not ask her to sig	gn any discharge					
	documents, and s	she did not receive any					
	documentation a	t the time of the meeting,					
	or since.						
	Resident B's fam	ily member #2, who was					
	responsible for n	naking health care					
	decisions for Res	sident B, was interviewed					
	on 7/05/12 at 10:	00 a.m. She indicated					
	she participated	in the above meeting by					
	phone. She also i	indicated the facility said					
	"sure" and "abso	lutely" when asked if the					
	resident could re	turn to the facility after					
	her hospital stay.	She also indicated she					
		ed any discharge forms or					
	documentation.	-					
							<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 20 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155790	B. WIN	NG		07/03/2012
NAME OF F	DDOVIDED OD GUDDI IEI		_	STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF			14751 C	CAREY RD	
		CARE AND REHAB-BRIDGEWA	TER	CARME	L, IN 46033	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)	DATE
	During an interview with the Executive					
		/12 at 4:00 p.m., he				
	indicated he had					
		o provide related to the				
	discharge of Res	sident B.				
	2 A facility noti	cy dated 4/28/09 titled				
	, , , , , , , , , , , , , , , , , , ,	sfer of the Resident"				
	indicated:	ister of the Resident				
	marcatea.					
	"Definitions:					
	Discharge: To le	eave the center without				
	plans or intention	n to return to the center				
	(i.e., discharge to	o home, a lower level of				
	care or another l	ong term care center,				
	death).	,				
		4				
		ve the center with plans				
		return (i.e., transfer to an				
	acute care center	r for appropriate care).				
	Procedure:					
	Discharge home	or another level of care:				
	1 P1. in 11: 1					
	_	arge procedure and				
		nt and give copy of				
		scharge Notice as				
	required. Include	_				
	member/respons	ible party				
	2 Provide educe	ation to resident and/or				
	family member/i					
	1011111y 111C1110C1/1	responsible				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 21 of 29

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ILDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 03/2012			
	PROVIDER OR SUPPLIES	R CARE AND REHAB-BRIDGEWA	TER	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX CROSS-REFERENCED TO THE A DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE		
	1 2	ormation that may be harge planning may ot limited to:							
	a. Where and from receive care	om whom the resident will							
	b. Resident's hea	alth condition							
	g. Summary of I status	resident's current health							
	_	ischarge summary and lan of care form							
	summary and po	and /or family sible party sign discharge ost discharge care form e of medications.							
	and/or represent	form to the resident ative or person(s) care and place the signed orm in the resident's"							
	This federal tag IN00109442.	relates to Complaint							
	3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(D) 3.1-12(a)(9)(E)								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 22 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION 00	СО	ATE SURVEY MPLETED /03/2012		
	PROVIDER OR SUPPLIER	CARE AND REHAB-BRIDGEWAT	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD TER CARMEL, IN 46033					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO I	ON SHOULD BE	(X5) COMPLETION DATE		
mo	3.1-12(a)(9)(F)	ESC IDENTIFICATION (1710	,		Bills		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 23 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155790		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE : COMPL 07/03/	ETED	
		155790	B. WIN	G		07/03/	2012
	PROVIDER OR SUPPLIER O TRANSITIONAL (CARE AND REHAB-BRIDGEWAT	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
SS=G	FREE OF ACCIL HAZARDS/SUPI The facility must environment rem hazards as is poreceives adequa assistance device. Based on record facility failed to supervision and a identified and imresident (Resider injuries when she and received injulower leg which transport to the hard treatment, include deficient practice reviewed for safe sample of 5. Findings include The record of Recon 7/02/12 at 10 included, but we post right above 3/03/12, legal blicongestive heart chronic obstruction renal insufficient venous stasis ulcomestive mous stasis ulcomestive material insufficient venous stasis ulcomestication in the province of the province o	ensure that the resident tains as free of accident saible; and each resident te supervision and es to prevent accidents. The review and interview, the ensure adequate assistive devices were plemented to prevent a at C) from suffering the fell from her wheelchair tries to her head and left required emergency cospital and subsequent ing stitches. This that affected 1 resident of 3 ety interventions in a sety interventions in a sident C was reviewed to a.m. Diagnoses the not limited to, status the knee amputation andness, hypertension, failure, atrial fibrillation, we heart disease, chronic try, hard of hearing, and the error of the left lower tent C was admitted to	F03	23	F323 The facility provides that residents receive adequate supervision and assistance devices to prevent accidents a possible. 1. Resident C received to correct assistive devices, including placement of a bed and a wheelchair alarm, a supervision to prevent accider upon admission. The resider care plan was implemented at reviewed by the interdisciplinateam and interventions were printo place as needed. Res C did not experience any other falls while in the facility. 2. Residents at risk for far are assessed upon admission and as necessary thereafter, and will be assessed for correct assistive devices, supervision, and any other appropriate fall prevention interventions, inclustransfer modalities by the interdisciplinateam with each new fall at morning clinical meeting. A fall risk assessment is implemented during the admission process	he and ats at's ad ary but Ils , ed	07/20/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 24 of 29

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DITT	A BUILDING 00		COMPLETED			
155790			A. BUILDING B. WING			07/03/2012		
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATE			-ED		CAREY RD			
MINDKEL	J IRANOITIUNAL	CARE AND REHAD-BRIDGEWAI	∟r t	CARIVIE	EL, IN 46033			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG				TAG			DATE	
					whereas appropriate interven			
	An initial Minin	num Data Set assessment,		are put into place. An ini				
	dated 3/23/12 in	ndicated Resident C was			Plan is updated when needed			
		nitively impaired, did not			when fall interventions are identified. 3. The interdisciplinary team, including nurse management, will be in-			
		equired staff assistance for						
		•						
	all activities of c	iany nving.						
					serviced relative to ensuring			
	A hospital "Disc	charge Summary," dated			resident environment remains	3		
	3/08/12, indicate	ed Resident C had been			free of			
	admitted to the hospital on 2/26/12 with a gangrenous right lower extremity. She underwent an above the knee amputation on 3/03/12, and was discharged to the facility on 3/08/12 for rehabilitation and				accident			
					hazards/supervision/devices,			
					including but not limited to, assessment/implementation a	and		
					appropriate interventions.	ariu		
					Nursing Staff			
					will be in-serviced by the Staf	f		
	wound care.				Development Coordinator on			
					providing			
	A "Morse Fall R	Risk Scale" assessment			each resident with the require	d		
	was done on 3/0	9/12, with a resultant			level of supervision and			
	score of 75. A "	Morse" score of 45 or			assistance to			
	higher is considered to be at high risk for				prevent accidents. The interventions are monitored by	,,		
	•	· ·			the nursing staff	у		
	falls. The assessment documented that Resident C had a history of falls, was non-ambulatory, and over-estimated or forgot limitations. Physician's Admission Orders, dated				on daily rounds. Falls and /o	r		
					interventions will be reviewed			
					clinical			
					(Monday through Friday), as			
					appropriate, to assure that			
					interventions are			
	3/08/12, indicate	ed no safety interventions.			in place.	100		
	A nurse's progress note dated 3/09/12 at 7:09 p.m., indicated Resident C had wheelchair and bed alarms and her bed in				Weekly fall meetings, to discu all falls occurring that week, a			
					conducted by the Director of	.		
					Nursing, or designee.			
					4. The Performance			
					Improvement Committee			
	low position.				assesses the falls program or	1		
					an ongoing basis and at least			
	Nurse's progress notes indicated:				annually. Director of Nursing,	, or		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING COMPLETE			ETED		
155790		A. BUII B. WIN			07/03/2	2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATE			14751 CAREY RD CARMEL, IN 46033				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
IAU	3/08/12 9:31 p.m. Resident C) old is a new above the right legShe is likely to notify sets staff needs to personal staff know her new and staff know her new and staff know her new at the night. Three Pt. said "please houtside" 3/12/12, "Pt. has (acute care hosping sliding to the flow She sustained a composition of the sustained and the staff know her new attached property." During an intervious number of the sustained and the size of the eyindicated the low centimeters. She called and that staff both wound area.	n., "Received a (age of female pt. (patient) who he knee amputee on the legally blind, and not taff of her needs, therefor riodically check on her." m., "Pt. does not let eeds" n. "Pt hallucinating during separate occasions, the help me to bed, I am been transferred to ital) for evaluation after or in the dining room. Cut to right eyebrow and a her lower left leg. Chair d functioning. Leg rests		IAU	designee, will review findings from the weekly fall meetings and report the Performance Improvement committee ongoing. 5. Completion Date: 7/20/2012.	t to	DATE
ı	and Emergency integration recommends		1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet Page 26 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION N		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
155790		B. WIN		07/03/2012			
			p. ,,, 11		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					CAREY RD		
KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATE							
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re COI	MPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	arrived and assu	med care.					
	Resident C retur	rned to the facility on					
		day hospital stay. A					
		Patient Transfer Report"					
	_	dated 3/16/12, indicated:					
	101 Resident C, C	auca 5/10/12, maicatea.					
	IIThometication	(age of Decider t C) -14					
	_	(age of Resident C) old					
		brought to the ER from					
		e after the patient fell out					
	of her wheelchair and hit her head on the wood floorthere was a positive loss of consciousnessshe does have approximately a 1.5 cm (centimeter) laceration over her right eyebrow. She does complain of left lower extremity pain by her skin tear. Review of systems: She does complain of head pain at her laceration and left lower extremity pain where there is a skin tear.						
	cxtremity pain w	viicie tileie is a skiii tear.					
	Impression: 1. A (age of Resident C) year old who fell from a wheelchair and hit her head on the wood floor.						
	2. Question of odontoid fracture with question epidural versus subdural hematoma" Resident C was discharged from the hospital back to the facility on 3/16/12."						
			\perp				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet Page 27 of 29

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3		(3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDING 00		COMPLETED	
155790			B. WING 07/03/2012				
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF TROVIDER OR SUITEER					CAREY RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-BRIDGEWA	TER	CARME	EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG				TAG	DEFICIENCY)	DATE	
		0.244.544.2					
	1 0	ess note of 3/16/12 at 9:48					
	1 ^	Received a (age of					
		old female pt. from (acute					
		he has stitches above her					
	1 -	ue to a recent fallShe					
	has a skin tear to						
	-	d to anticipate her needs,					
		y to communicate her					
	needs to staff." Care plans for Resident C initiated beginning 3/09/12 indicated no care plans for fall risk or other safety measures prior to Resident C returning from the hospital on 3/16/12.						
	Occupational an	d physical therapy					
	evaluations were completed on 3/09/12. Neither evaluation had any assessment of, or recommendations for interventions, for Resident C's risk for injury secondary to falls, including but not limited to, a lack of assessment for wheelchair positioning or safety devices. During an interview on 7/03/12 at 4:00						
		xecutive Director and					
	Director of Nursing present, the D.O.N. indicated she believed the facility's responsibility to meet the safety needs of						
		-					
	Resident C had been met, because the facility had implemented bed and chair alarms, a low bed, and had done a fall risk						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZC4411

Facility ID: 012548

If continuation sheet

Page 28 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155790		A. BUILDING 00 COMP			COMPL: 07/03/	ETED		
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATE			STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	she was aware no assessments or in done. She indicate facility was not or plans to meet a reprior to 21 days a admission to the	terventions had been ted she believed that the obligated to develop care esident's individual needs after a resident's						

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Event ID: ZC4411

Facility ID: 012548

If continuation sheet Page 29 of 29